ACT 299

Cost Reporting and Rate Reimbursement Sub-committee Report

Background

Rates for almost all Home and Community Based Services (HCBS) are not currently established based on the cost of providing services. The sole exception is the rate for Adult Day Health Care (ADHC). Rates have been set in a variety of ways, including being mandated in settlement agreements resulting from lawsuits. Cost reports or other cost data are not currently collected from HCBS providers (other than ADHC), although they were collected from some providers in the past. Many providers, however, contend that the current rates do not reflect the true costs of providing the services and in some cases are actually below costs. Absent reliable cost data, it is impossible to determine the actual facts regarding the costs of providing HCBS services.

There have been several cuts to HCBS rates in the past couple of years (though not all have been cut equally). The lack of any established methodology for setting rates, and the unequal application of rate cuts, has led to considerable variation between rates in various HCBS programs. This is true even in cases where the service definitions are very similar and the tasks performed by workers are essentially the same. Providers who provide more than one program often note that lower paying programs (typically those that serve elders or persons with physical disabilities) are subsidized by the higher paying programs (typically serving persons with developmental disabilities). Many note that they could not serve the elder population at the current rates without this "subsidy" from the other programs. Some providers have stopped providing the services with lower rates. Without cost data, it is not known whether these rate differentials are justified.

Many states collect cost reports from HCBS providers and use those in cost-based rate methodologies. The neighboring state of Texas is one example. Louisiana currently uses cost-based methodologies to reimburse institutional long term care providers (nursing homes and intermediate care facilities/DD). While such methodologies determine what a rate should be, it is important to remember that actual payment rates are ultimately dependent upon appropriation of funds by the legislature.

Goal

Act 299 charged that the plan address mandatory cost reporting by providers of HCBS to verify expenditures and for use in determining appropriate reimbursement rates. It further charged that the plan include a review of reimbursement rate methodologies that promote administrative efficiencies and reflect the cost of providing quality HCBS, to be inclusive of but not limited to the cost of the new requirements concerning medication administration.

The Sub-Committee acknowledged that the review and development of a reimbursement methodology would take much longer than the time available for this report. Therefore members decided to focus on the following immediate goals, with the understanding that work would continue beyond this initial report:

- Determine if there is a consensus in favor of requiring cost reporting.
- Identify key issues in adopting cost reporting.
- Identify or develop key elements of a cost reporting format.
- Examine considerations for possible rate methodologies based on cost reports.

- Recommend principles or factors to be considered in developing a rate methodology.
- Recommend a few options for further study, including development of "interim" rate methodology until cost reports could be implemented.

Strategy and Recommendations

The Sub-Committee reviewed cost reports from the state of Texas and the report currently used by the ADHC providers in Louisiana. The group also examined the basics of how the ADHC rate methodology works and noted similarities to other methodologies in other states and/or programs. The group discussed various issues involved in allocating costs between programs, including the advisability of having multiple cost reports. The group discussed the importance of having audited data upon which to base rates, and that there must be a delay between the start of cost-reporting and when rates derived from the reports could be produced. This led to a discussion of developing "interim" rates. The group discussed various factors in addition to cost that should be taken into account in the devising of a rate methodology. These included the use of groupings by size or region, the use of quality measures, and the use of acuity factors. The group reviewed a study done by Myers & Stauffer for the state of Alaska, which examined in detail many of these same issues.

The Sub-Committee makes the following recommendations:

Determine if there is a consensus in favor of requiring cost reporting.

- All HCBS providers should file cost reports with the state. Providers should file a single report that includes all HCBS services provided, but should file separate reports for each license number they hold. Allowable cost should be in accordance with CMS guidelines (HIM 15).

Identify key issues in adopting cost reporting.

- Initial and ongoing training should be available for providers, using online resources where feasible.

Identify or develop key elements of a cost reporting format.

- To the extent possible, the cost report format should be the same for all HCBS services.
- Develop procedures for auditing of cost report submitted by providers
- To the extent possible, cost reports should be submitted electronically

Examine considerations for possible rate methodologies based on cost reports.
Recommend principles or factors to be considered in developing a rate methodology.

- Reimbursement methodologies based on costs should be developed for HCBS services. The initial focus should be on the high volume, high expenditure services which are primarily forms of personal assistance (e.g. Personal Assistance Services, Individual & Family Support, Long Term Personal Care) and on Support Coordination.
- Any adopted methodology should contain appropriate mechanisms to ensure sufficient funds go toward direct care and to promote adequate wages for direct support workers.

- Reimbursement methodologies for services which are substantially identical in scope should be the same. It is expected that using the same reimbursement methodology will equalize rates at an appropriate level.

Recommend a few options for further study, including possible development of "interim" rate methodology until cost reports could be implemented.

- Primary focus should be on cost-based methodology. In the interim DHH will review any existing data to inform rate methodology i.e., provider data, other states, CMS and compare to current rates.
- Initial methodology should assume a single state-wide rate for each service. The use of rate differentials based on groupings should be a focus for later after sufficient data is available. Possible groups to consider for future use should definitely include acuity and quality.

Deliverables & Timelines

Deliverable	Target Date
Initial Draft cost report format	December 31, 2011
Rules & Procedures	Publish NOI by March 31, 2012
Training of Providers	May 31, 2012
"Mandated Cost Reports" Rule	July 1, 2012
Cost Report Due	November 30, 2012
Audit	After November 30, 2012

The Rate Reimbursement and Cost Report Sub-Committee recommends that the group continue to meet on a regular basis to develop a rate methodology and subsequent recommendations at the time that cost reports are submitted (November 30, 2012).